Published in final edited form as:
Ann Intern Med. 2011 July 19; 155(2): 122–126. doi:10.1059/0003-4819-155-2-201107190-00348.

Balancing Punishment and Compassion for Seriously Ill Prisoners

Brie A. Williams, MD[*,†], **Rebecca L. Sudore, MD**[*,†], **Robert Greifinger, MD**[‡], and **R. Sean Morrison, MD**[§,‖,¶]

[*]University of California, San Francisco, Division of Geriatrics

[†]San Francisco VA Medical Center, Health Services Research and Development Research Enhancement Award Program

[‡]Criminal Justice Research and Evaluation Center, John Jay College of Criminal Justice, City University of New York

[§]The Brookdale Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine

[‖]The National Palliative Care Research Center, New York NY

[¶]The James J. Peters VA Medical Center, Bronx NY

Abstract

Compassionate release is a mechanism to allow some eligible, seriously ill prisoners to die outside of prison before sentence completion. It became a matter of federal statute in 1984 and currently has been adopted by the majority of U.S. prison jurisdictions. Incarceration is justified on 4 principles: retribution, rehabilitation, deterrence, and incapacitation. Compassionate release derives from the theory that changes in health status may affect these principles and thus alter justification for incarceration and sentence completion. The medical profession is intricately involved in this process because eligibility for consideration for compassionate release is generally based on medical evidence. Due to an aging prison population, overcrowding, rising deaths in custody, and soaring criminal justice medical costs, many policy experts are calling for broader use of compassionate release. Yet, the medical eligibility criteria of many compassionate release guidelines – which often assume a definitive prognosis – are clinically flawed and procedural barriers may further limit their rational application. We propose changes to address these flaws.

Compassionate release is a mechanism that allows some eligible, seriously ill prisoners to die outside of prison before sentence completion. Compassionate release programs are based on 2 premises: (1) it is ethically and legally justifiable to release a subset of prisoners with life-limiting illnesses, and (2) the financial costs to society of continuing to incarcerate such persons outweigh the benefits. The U.S. federal prison system and the majority of state systems have a compassionate or medical release program.(1,2) With increasing numbers of older prisoners, overcrowding, rising numbers of in-prison deaths, and soaring criminal

Contact Information Brie Williams, MD, MS, Division of Geriatrics, University of California, San Francisco Phone: 415-221-4810 x2681 Fax: 415-750-6641 brie.williams@ucsf.edu.
Address for reprint requests Brie Williams UCSF Division of Geriatrics 4150 Clement Street, Box 181-G San Francisco CA 94121
Complete postal address for all authors Brie Williams UCSF Division of Geriatrics 4150 Clement Street, Box 181-G San Francisco CA 94121
Rebecca Sudore UCSF Division of Geriatrics 4150 Clement Street, Box 151-R San Francisco CA 94121
Robert Greifinger 32 Parkway Drive Dobbs Ferry, NY 10522
R. Sean Morrison Brookdale Department of Geriatrics and Palliative Medicine Box 1070 Mount Sinai School of Medicine One Gustave Levy Place New York NY 10029

justice costs, correctional and public policy experts are calling for broader use of compassionate release.(3,4,5)

Compassionate release consists of 2 entwined, but distinct elements: eligibility (based on medical evidence) and approval (based on legal/correctional evidence).(5) We argue that the medical eligibility criteria of many compassionate release guidelines are clinically flawed because they rely heavily on the inexact science of prognostication and additional procedural barriers may further limit their rational application. Given that early release is politically and socially charged and that eligibility is based largely on medical evidence, it is critical that such evidence be based upon the best possible scientific evidence and that the medical profession help minimize medical-related procedural barriers. We propose changes to make compassionate release guidelines more clinically meaningful and to address medical-related procedural barriers.

The history and rationale underlying compassionate release

Compassionate release is a matter of federal statute under the Sentencing Reform Act of 1984,(1) and now all but 5 states have some mechanism through which dying prisoners can seek release.(2,6,7) Additionally, in the past 3 years, 12 states passed legislation to expand early release programs for dying and incapacitated persons.(8–12) Whereas medical eligibility guidelines vary by jurisdiction; most require: (1) a terminal (or severely debilitating) medical condition, (2) a condition that cannot be appropriately cared for within the prison, and (3) a prisoner who poses no threat to society.(5,13)

Compassionate release was established under the premise that changes in health status may alter justification for incarceration. Incarceration is based on 4 principles (5,14): 1) as *retribution* through deprivation of liberty, when other punishment is deemed insufficient, 2) as *rehabilitation* (e.g., drug-treatment or educational programs), 3) as *deterrence* for future criminal acts, and 4) as *incapacitation*, by separating prisoners from society to enhance public safety. These justifications may be substantially undermined for prisoners who are too ill or cognitively impaired to be aware of punishment, too sick to participate in rehabilitation, or too functionally compromised to pose a risk to public safety. In recognition of society's need for retribution for particularly heinous criminal acts, virtually all states exclude some prisoners from eligibility based on crime severity.(15)

Compassionate release was also designed to address correctional costs. Between 1982 and 2006, U.S. state and federal prison populations grew 271%,(16) prisoners 55 years or older increased 418%,(17–19) and spending increased 660%.(20) For the 79,100 prisoners over age 55,(21) the cost of incarceration is over 3 times that of younger prisoners – primarily due to healthcare costs.(22) Although releasing prisoners who are very close to death (days to weeks) may simply shift healthcare costs (to Medicare/Medicaid,)(23) in cases felt to be appropriate and safe, earlier release will likely reduce costs related to hospital security, medical transport for treatments such as dialysis, and construction of disability-accessible, protective housing.(4,13) Indeed, the average annual costs for healthcare, protective transportation, and guards for 21 seriously-ill prisoners in California (just 0.01% of the state's prison population) exceed $1.97 million per prisoner.(24) In comparison, the median annual cost of nursing home care in California is $73,000 per person.(25) Further discussions of the ethical, legal, and financial aspects of compassionate release are reviewed elsewhere.(5,13)

The precise number of compassionate release requests is unknown, in part because many prisoners die during review.(4,13,23) What is known is that a small percent of dying prisoners are granted compassionate release. For example, in 2008 there were 399 deaths in the Federal Bureau of Prisons and 27 compassionate release requests approvals. Six

applicants died during the final review process, Table 1.(26,27) We do not mean to suggest, given the importance of public safety, that any death in prison be viewed as a failure of the compassionate release process. Yet, medical and procedural flaws in eligibility guidelines described below coupled with the small number of persons who receive compassionate release suggest the importance of reevaluating and transforming current guidelines.

The compassionate release process

Compassionate release varies by jurisdiction. Within federal prisons, a prisoner or advocate initiates a written appeal describing the “extraordinary and compelling reasons” for release and proposes release plans. The application receives 4 additional levels of review after a medical evaluation. State processes have differing requirements for eligibility, application, and approval.(15) The review process in both federal and state systems can extend for months, and occasionally years.(13)

Medical-related flaws in compassionate release programs

Compassionate release eligibility guidelines are often fraught with clinical flaws. To meet most guidelines, prisoners must have a predictable terminal prognosis, be expected to die quickly, and/or have health or functional status that substantially undermines the aforementioned justifications for incarceration. As such, compassionate release requires that physicians predict not only limited life expectancy, but functional decline as well. Prognosis is difficult to establish for conditions such as advanced liver, heart and lung disease, and dementia (28–29) - increasingly common causes of death and disability in prisons.(30–32) Moreover, for patients with more predictable prognoses such as cancer, functional trajectories are variable and unpredictable, often declining only in the last weeks of life.(33,34)

Reliance on prognostication can create a “Catch 22”: if compassionate release is requested too late, an eligible prisoner will die before their petition is completed; too early and a terminally ill prisoner in good functional health can be released, live longer than expected, and perhaps pose a threat to society. Yet, requiring a predictable, time-limited prognosis (e.g., 6 months or less) excludes prisoners with severe, but not end-stage, dementia, persistent vegetative state, or end-stage organ disease (e.g., oxygen-dependent COPD). Some such patients may live for months to years, at great expense to criminal justice systems, incapable of posing harm, participating in rehabilitation, or, in the case of dementia, experiencing punishment. These flaws reflect a fundamental tension between the eligibility guidelines for compassionate release and people's actual disease trajectories.

Procedural barriers may also hamper medically-eligible persons from obtaining compassionate release and invite potential inequity. For instance, persons with profound cognitive incapacities (the majority of patients with advanced illness (28,35)), could be incapable of completing a written petition. Prisoners also have the nation's lowest literacy rates,(36) are frequently distanced from family or friends impeding access to social support to navigate the process,(37) and many are not aware that early release programs exist.(4) Yet, formal mechanisms to assign and guide a prisoner advocate have neither been universally accepted nor optimized. For example, for a terminally ill prisoner in California, the warden must enable the prisoner to designate an outside agent to act as an advocate.(12) However, once an advocate is appointed, there are no formal guidelines to help the agent navigate the system. In states without formal advocates, (e.g., New York) implicit expectations have arisen that prison medical staff should advocate for such prisoners. This expectation is not formally codified and is infrequently operationalized.(13) Another procedural barrier is time: while a few states, such as Vermont, have a “fast-track” option for imminently dying prisoners,(13) for many prisoners the process may be too lengthy to

achieve evaluation for release before death. While these procedural barriers do not relate directly to the clinician's role, they may act as functional barriers to a meaningful process and should be reformed along with medical eligibility criteria.

Addressing medical-related flaws in compassionate release eligibility guidelines

We recommend the development of standardized national guidelines by an independent advisory panel of palliative medicine, geriatrics, and correctional healthcare experts. Such external evaluation would require transparency and public sharing of information about the varied compassionate release processes across jurisdictions and could help identify other avenues for improvement system-wide.(38) At a minimum, the new guidelines should embrace evidence-based principles and a transparent process that includes: (1) assignment of a prisoner advocate to help navigate the process and represent incapacitated prisoners; (2) a fast-track option for evaluation of rapidly-dying prisoners; and (3) a well-described and disseminated application procedure. The guidelines also must delineate distinct roles for physicians (assessment of medical eligibility) and parole boards/corrections (balancing prisoner health, public safety, and retribution in the approval process).(39) Other areas that should be reviewed include mechanisms for identifying potential candidates and avenues for addressing request denials.(4,13,38) As with other guidelines (40), standardization of compassionate release guidelines, in concert with a patient advocate, should help avoid inequities in compassionate release access - particularly for those too cognitively impaired to advocate for themselves.

We also propose that national criteria for medical eligibility for compassionate release categorize seriously-ill prisoners into 3 groups, based not only upon prognostication, but also disease trajectory, and functional and cognitive status. These groups consist of: (1) prisoners with a terminal illness with predictably poor prognoses; (2) prisoners with Alzheimer and related dementias; and (3) prisoners with serious, progressive, nonreversible illness with profound functional/cognitive impairments. Use of such an evidence-based categorization could provide a framework within which medical professionals' roles can be tailored (Table 2), and serve as the starting point for the redesign of medical eligibility criteria, release settings, and in-prison medical needs.

Finally, to address concerns about retribution and public safety, we propose that recall mechanisms for prisoners whose conditions improve substantially after release (17) be expanded to all state and federal programs.

Palliative medicine and the criminal justice system

Efforts to transform compassionate release programs should concurrently develop prison-based palliative care. Any prisoner with an illness or debilitating condition that is serious enough to consider a compassionate release application would benefit from a palliative medicine evaluation to decrease their symptom burden while awaiting a decision. Additionally, while incarceration may no longer be justified for prisoners who are both medically eligible and meet legal/correctional approval, palliative care should be provided to the many prisoners with serious illness who will not be eligible for early release. At present, access to prison palliative care is limited. For example, only 75 of 1719 state correctional facilities and 6 of 102 federal facilities have hospices.(41,42) Additionally, as with palliative care programs in the community,(42,43) prison-based palliative care programs are likely to improve healthcare while lowering costs.(3,37)

Conclusion

Although compassionate release could address fiscal pressures posed by the aging prison population, medical and procedural barriers may prevent its rational application. Determining medical eligibility, as distinguished from approval, for compassionate release is a medical decision and falls within physicians' scope of practice. Moreover, many states are considering expanding medical eligibility to include physical incapacity and/or the “elderly” in addition to terminal diagnoses. Physicians thus have an opportunity to use their unique expertise and knowledge of prognosis, geriatrics, cognitive and functional decline, and palliative medicine to ensure that medical criteria for compassionate release are appropriately evidence-based. Using this medical foundation, criminal justice professionals can balance the need for societal punishment with an eligible individual's appropriateness for release. As a society, we have incorporated compassionate release into most prison jurisdictions. As a medical profession, we must lend our expertise and ethical suasion to ensure that compassion is fairly delivered.

Acknowledgments

The authors would like to acknowledge the editorial contributions of Amy J. Markowitz

Funding Support Brie Williams received funding from the Brookdale Leadership in Aging Fellowship and the National Institute of Aging (K23AG033102). Sean Morrison was supported by a Mid-Career-Investigator Award in Patient-Oriented Research (K24 AG022345) from the National Institute on Aging and by the National Palliative Care Research Center. Dr. Sudore is funded, in part, by a Pfizer Fellowship in Clear Health Communication. These funding sources had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript. Drs. Morrison, Williams and Sudore are employees of the Department of Veterans Affairs. The opinions expressed in this manuscript may not represent those of the VA.

References

(1). Compassionate Release (Procedures for the Implementation of 18 U.S.C. 3582(c)(1)(A) and 4205(g)), 28 C.F.R. Sect. 571.60–571.64. 1994.

(2). National Institute of Corrections. Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates. NIC Accession No. 018735. Department of Justice; Washington DC: 2004.

(3). Anno, BJ.; Graham, C.; Lawrence, JE.; Shansky, R. Correctional health care: Addressing the needs of elderly, chronically ill, and terminally ill inmates. Criminal Justice Institute; Middletown, CT: 2004. p. 148

(4). Gubler, T.; Petersilia, J. Elderly prisoners are literally dying for reform. Stanford University, Criminal Justice Center; Palo Alto (CA): 2006.

(5). Berry W. Extraordinary and compelling: A re-examination of the justifications for compassionate release. MD Law Rev. 2009; 68(4):850–888.

(6). American Correctional Association. Corrections Compendium. May. 2001 Survey: The Elderly Inmate – Part 5: Release Provisions.

(7). Abner, C. Graying prisons: States face challenge of an aging prison population. Council of State Governments. 2006. Available online: http://www.csg.org/knowledgecenter/docs/sn0611GrayingPrisons.pdf

(8). The Vera Institute of Justice. It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release. Tina Chiu; New York, NY: April. 2010 Available from: http://www.vera.org/content/its-about-time-aging-prisoners-increasing-costs-and-geriatric-release

(9). Gorman, B. With soaring prison costs, states turn to early release of aged, infirm inmates. National Conference of State Legislatures; Washington DC: 2008.

(10). King, RS. The Sentencing Project; Washington DC: 2008. A change in direction? State sentencing reforms 2004–2006.

(11). O'Meara GJ. Compassion and the public interest: Wisconsin's new compassionate release legislation. Federal Sentencing Reporter. 2010; 23(1):33–38.

(12). An act to add Section 2065 to the Penal Code, relating to parole. California Senate Bill 1399; 2010.

(13). Beck J. Compassionate release from New York State prisons: Why are so few getting out? J Law Med Ethics. Fall;1999 27(3):216–233. [PubMed: 11067598]

(14). Kadish, SH.; Schulhofer, SJ.; Steiker, CS. Criminal law and its processes: Cases and materials. 8th ed.. Aspen Publishers; New York (NY): 2007. p. 1173

(15). Russell MP. Too little, too late, too slow: Compassionate release of terminally ill prisoners – is the cure worse than the disease? Widener J Pub L. 1993; 3(3):799.

(16). Bureau of Justice Statistics. Office of Justice Programs. Key facts at a glance: Correctional populations [Internet]. Department of Justice; Washington (DC): [updated 2010 Sep 21, cited 2010 Feb 6]. Available from: http://bjs.ojp.usdoj.gov/content/glance/tables/corr2tab.cfm

(17). Goettig A. The elderly in prison: Issues and perspectives. J Res Crime Delinq. Jul; 1983 20(2): 291–309.

(18). Bureau of Justice Statistics. Office of Justice Programs. Prisoners in 2006 [Internet]. Department of Justice; Washington (DC): [2007 Dec 5, cited 2008 Apr 20]. Available from: http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=908

(19). Bureau of Justice Statistics. Office of Justice Programs. Prisoners in 1983. Department of Justice; Washington, DC: 1984.

(20). Bureau of Justice Statistics. Office of Justice Programs. Key facts at a glance: Direct expenditures by criminal justice function, 1982–2006. Department of Justice; Washington (DC): [updated 2010 Sep 21, cited 2010 Sep 5]. Available from: http://bjs.ojp.usdoj.gov/content/glance/tables/exptyptab.cfm

(21). Bureau of Justice Statistics. Office of Justice Programs. Prisoners in 2009 [Internet]. Department of Justice; Washington (DC): [2010 Dec, cited 2011 Feb 4]. Available from: http://bjs.ojp.usdoj.gov/content/pub/pdf/p09.pdf

(22). The Pew Center on the States. One in 100: Behind bars in America 2008. The Pew Center on the States. The Pew Charitable Trusts; Washington (DC): Feb. 2008 p. 35

(23). Maul, FW. Delivery of end-of-life care in the prison setting. In: Puisis, M., editor. Clinical practice in correctional medicine. Mosby; Elsevier (PA): 2006. p. 529-537.

(24). Ferriss, Susan. Medical Parole to Cut California's Prison Costs? The Sacramento Bee. March 29. 2010 Available from: http://www.scrippsnews.com/content/medical-parole-cut-california-prison-costs

(25). Genworth Financial. Cost of Care Survey: Home Care Providers. Adult Day Health Care Facilities; Assisted Living Facilities and Nursing Homes; Richmond, VA: 2010.

(26). Bureau of Justice Statistics. Office of Justice Programs. Deaths of prisoners under federal jurisdiction by sex and cause of death, 1999–2008. Department of Justice; Washington (DC): Internet[2009 Dec, cited 2010 Dec 8]. Available from: http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=194

(27). United States Department of Justice. Federal Bureau of Prisons. Requests for reduction in sentence received in central office. Last updated 23 March 2010

(28). Shega J, Tozer C. Improving the care of people with dementia at the end of life: The role of hospice and the US experience. Dementia. Aug; 2009 8(3):377–389.

(29). Fox E, Landrum-McNiff K, Zhong Z, Dawson NV, Wu AW, Lynn J. Evaluation of diagnostic criteria for determining hospice eligibility in patients with advanced lung, heart, or liver disease. JAMA. 1999; 282(17):1638–1645. [PubMed: 10553790]

(30). Mumola, CJ. Medical causes of death in state prisons, 2001–2004. Department of Justice; Washington (DC): Jan. 2007 p. 12Bureau of Justice Statistics Data Brief. NCJ 216340. Available from: http://bjs.ojp.usdoj.gov/content/pub/pdf/mcdsp04.pdf

(31). Williams BA, Baillargeon J, Lindquist K, Walter L, Covinksy K, Whitson H, et al. Medication prescribing practices for older prisoners in the Texas prison system. Am J Public Health. Sep; 2009 100(4):756–761. [PubMed: 19762661]

(32). Williams B, Lindquist K, Hill T, Baillargeon J, Mellow J, Greifinger R, Walter L. Caregiving behind bars: Correctional officers reports of disability in geriatric prisoners. J Am Geriatr Soc. Jul; 2009 57(7):1286–1292. [PubMed: 19582902]

(33). Lunney, Lynn J, Foley DJ, Lipson S, Guralnik JM. Patterns of functional decline at the end of life. JAMA. 2003; 289(18):2387–2392. [PubMed: 12746362]

(34). Gill TM, Gahbauer EA, Han L, Allore HG. Trajectories of disability in the last year of life. N Engl J Med. 2010; 362(13):1173–1180. [PubMed: 20357280]

(35). Somogyi-Zalud E, Zhong Z, Lynn J, Hamel MB. Elderly persons' last six months of life: Findings from the hospitalized elderly longitudinal project. J Am Geriatr Soc. May; 2000 48(5suppl):S131–S139. [PubMed: 10809466]

(36). Kirsch, IS.; Jungeblut, A.; Jenkins, L.; Kolstad, A. Adult literacy in America: A first look at the findings of the national adult literacy survey. National Center for Education Statistics; Washington (DC): 1993. p. 176NCES 93275

(37). Linder JF, Meyers FJ. Palliative care for prison inmates: “Don't let me die in prison.”. JAMA. Aug; 2007 298(8):894–901. [PubMed: 17712073]

(38). Dubler NN. The collision of confinement and care: End-of-life care in prisons and jails. J Law Med Ethics. 1998; 26:149–156. [PubMed: 11657351]

(39). SCP: Position Statements and Guidelines. Society of Correctional Physicians; Chicago (IL): InternetPosition statement: Compassionate medical release; 2009 Aug 13 [cited 2010]. Available from: http://www.corrdocs.org/framework.php?pagetype=newsstory&guidelineid=10110&bgn=2

(40). Nelson A. Unequal treatment: Confronting racial and ethnic disparities in health care. J Natl Med Assoc. Aug; 2002 94(8):666–668. [PubMed: 12152921]

(41). [Accessed March 18, 2010] “End of Life Care in Corrections: The Facts” The National Hospice and Palliative Care Organization. Available from: http://www.nhpco.org/files/public/access/corrections/Corrections_The_Facts.pdf

(42). Stephan, JJ. Census of State and Federal Correctional Facilities, 2005. Department of Justice; Washington (DC): Oct. 2008 p. 28Bureau of Justice National Prisoner Statistics Program. NCJ 222182. Available from: http://bjs.ojp.usdoj.gov/content/pub/pdf/csfcf05.pdf

(43). Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. Sep; 2008 168(16):1783–1790. [PubMed: 18779466]

Ann Intern Med. Author manuscript; available in PMC 2011 August 29.

Table 1

Outcomes of Compassionate Release Requests that Reach Final Review Stage[*] in the Federal Bureau of Prisons[†‡]

Year	Federal Prison Population	Deaths in Federal Bureau of Prisons #[§]	Mortality Rate / 100,000 Federal Prisoners	Compassionate Release Requests Reaching Final Stage of Review #	Compassionate Release Requests Approved in Final Stage #	Compassionate Release Requests Denied in Final Stage, #	Applicants Who Died While Their Case was in the Final Review Process[//] #
2008	178,530	399	229	36	27	5	6
2007	176,346	368	211	30	16	10	6
2006	169,320	328	192	44	26	10	6
2005	175,954	388	233	36	18	10	8
2004	169,370	333	208	21	6	7	5
2003	173,059	347	227	46	25	11	8
2002	163,528	335	232	38	24	5	6
2001	156,993	303	221	34	26	4	3
2000	145,416	285	218	40	32	5	3

[*] To reach the final stage of the compassionate review process in the Federal Bureau of Prisons, the application has already been initiated by the inmate, citing both justification and post-release plans, recommended by the warden of the institution where the inmate is held (including attending physician's medical summary and life expectancy estimate), reviewed and approved by the Regional Director, reviewed and approved by the General Counsel of the Bureau of Prisons, evaluated and forwarded by the Medical Director or Assistant Medical Director of the Correctional Programs Division, and ultimately approved by the Director of the Bureau of Prisons. The Director of the Bureau of Prisons then forwards a motion for release to the U.S. Attorney in the district where the prisoner was sentenced, and to the sentencing court. (5) The data as reflected in this table considers the Director of the Bureau of Prisons the final review stage.

[†] All data for this table taken from the U.S. Department of Justice's “Requests for Reduction in Sentence Received in Central Office” (27) except where otherwise noted.

[‡] Of note, the numbers listed for each year reflect all activity during a calendar year. Approvals and denials may carry over from one year to the next. the numbers of approvals, denials and deaths in one year do not always add up to the total number of requests from that year.

[§] Data in this column taken from the U.S. Bureau of Justice Statistics' “Deaths of prisoners under federal jurisdiction by sex and cause of death, 1999–2008” (26).

[//] Death occurred before final decision made about Compassionate Release

Table 2

Proposed Categorization Scheme for Assessing Medical Eligibility for Compassionate Release for Seriously Ill Prisoners

	Prisoner Groups Based on Disease, Cognition and Functional Status			
	1. Terminal Illness with Predictable Prognosis		**2. Profound Cognitive Impairment / Dementia**	**3. Serious, Non-Reversible, Progressive Disease with Profound Cognitive and/or Functional Impairment***
Pace of disease progression and predictability of prognosis	Steady progression with predictable prognosis (months to years depending on stage at diagnosis)	Rapid progression with predictable poor prognosis (days - weeks)	Steady progression of disease, functional and cognitive impairment; long-term prognosis predictable (steady worsening of cognitive and functional abilities over years from diagnosis) until end-stage dementia when short-term prognosis is difficult to predict (months to years)	Steady progression of symptoms and functional impairment, unpredictable prognosis (months to years)
Disease Examples	Metastatic solid tumor cancers, Amyotrophic Lateral Sclerosis	Rapidly progressive malignancy, acute infection or vascular event with rapid decline and/or multi-organ failure	Alzheimer's and other dementias, Persistent Vegetative State	Oxygen-dependent COPD, NYHA Class IV Heart Failure, Advanced liver disease with cirrhosis
Primary medical criteria for release	Life expectancy/prognosis		Cognitive status	Cognitive and functional status
Need for fast-track assessment for compassionate release	No	Yes	No	No
Time point of assessment for potential medical eligibility	Diagnosis of new malignancy or rapidly progressive terminal illness		Annual medical evaluation or following acute event (e.g., stroke, hospitalization for pneumonia)	Annual medical evaluation or following seminal events (3 or more hospitalizations in a year, ICU admission, new inability to complete self-care activities)
Individual responsible for identifying candidate for potential eligibility and for initiating process	Physician/Healthcare Provider,† Patient, Advocate		Physician/Healthcare Provider,† Advocate	Physician/Healthcare Provider,† Patient, Advocate
Release site	Hospice/palliative care program, Family home-hospice		Nursing home/Family caregiver	Nursing home/Family caregiver
Alternative to release	Prison hospice		Prison dementia or long term care unit	Prison assisted living facility until end-stage; then prison hospice

*Functional impairment refers to nursing home-eligibility criteria, specifically impairment in 2 or more Activities of Daily Living

†The Society of Correctional Physicians Position Statement on Compassionate Release "encourages responsible prison and jail physicians to take a leading role in initiating and shepherding the medical release process for possible candidates." (39) Given that a prisoner with newly diagnosed profound dementia may be too cognitively impaired to initiate a request for release, the physician or a patient advocate would be the most appropriate person to initiate a request.